

**Child Find Referral Form  
(For Children age 3-5 years)**

**Child's Information**

Child's Name: \_\_\_\_\_ DOB: \_\_\_/\_\_\_/\_\_\_ Gender:  Male  Female  
Parent / Guardian: \_\_\_\_\_ Relation to Child: \_\_\_\_\_  
Address: \_\_\_\_\_ Phone #1: \_\_\_\_\_ Best Time: \_\_\_\_\_  
\_\_\_\_\_ Phone #2: \_\_\_\_\_ Best Time: \_\_\_\_\_  
Interpreter Needed:  Yes  No If Yes, Language: \_\_\_\_\_  
School District or County of Residence: \_\_\_\_\_  
Child Attends:  Head Start  School Dist. Preschool  Private Preschool  Childcare  None  
Medical Provider: \_\_\_\_\_ Phone: \_\_\_\_\_  
Address: \_\_\_\_\_ Fax: \_\_\_\_\_  
Reason for referral: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Date of ASQ, Peds, etc. \_\_\_/\_\_\_/\_\_\_ Date of Hearing Screen \_\_\_/\_\_\_/\_\_\_ Date of Vision Screen \_\_\_/\_\_\_/\_\_\_  
*(Please include copy of the entire developmental screening tool, such as the ASQ, as well as results of any hearing and vision screening. This will avoid duplication of efforts and allow for a more timely and appropriate evaluation.)*

**Referral and Consent to Share Information**

Based on concerns that I and my child's medical provider have about my child's development, I am requesting that my child be referred to Child Find to determine eligibility for preschool special education services. I authorize my child's medical provider \_\_\_\_\_ to release the complete medical file including results of developmental screening and any pertinent medical history of \_\_\_\_\_ (name of child) DOB \_\_\_/\_\_\_/\_\_\_ to \_\_\_\_\_ (Child Find Coordinator/School District) to be considered in determining whether the child is a child with an educational disability.  
**Signed:** \_\_\_\_\_ **Relation to Child:** \_\_\_\_\_ **Date:** \_\_\_/\_\_\_/\_\_\_  
Furthermore, I authorize \_\_\_\_\_ (Child Find coordinator/school district) to share the results of the evaluation with \_\_\_\_\_ (child's medical provider).  
**Signed:** \_\_\_\_\_ **Relation to Child:** \_\_\_\_\_ **Date:** \_\_\_/\_\_\_/\_\_\_

**Update from Child Find to Medical Provider (Child Find to Fax to Medical Provider if listed above)**

Child Find completed developmental screening of this child on \_\_\_/\_\_\_/\_\_\_  
 The child was evaluated on \_\_\_/\_\_\_/\_\_\_ and is...  
 Eligible for preschool special education and (circle all):  
SPL PT OT Behavioral Other: \_\_\_\_\_  
 Not eligible for preschool special education at this time, further developmental evaluation may be indicated. Follow up with medical provider recommended.  
 The child has not been in for screening or evaluation  
 The child did not qualify for special education but a developmental delay was confirmed. Follow up with medical provider recommended.  
 Please call me for more information regarding this child's screening/evaluation  
Completed by: \_\_\_\_\_ Phone: \_\_\_\_\_  
Signature: \_\_\_\_\_ Date: \_\_\_/\_\_\_/\_\_\_